		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0030015

Facility Name: WESTMONT CONVALESCENT CENTER

Address: 6501 SOUTH CASS AVENUE (Number) WESTMONT (City) 60559 (Zip Code)

County: DUPAGE

Telephone Number: (630) 960-2026 **Fax #** (630) 960-0480

IDPA ID Number: 36-3376606

Date of Initial License for Current Owners: 09/01/85

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[X]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) FLORA WEISS

(Title) GENERAL PARTNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA, PARTNER

(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,420	1
2		Skilled Pediatric (SNF/PED)			2
3	107	Intermediate (ICF)	107	39,055	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	215	TOTALS	215	78,475	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,392	2,963	8,463	20,818	8
9	SNF/PED					9
10	ICF	38,765	11,839	205	50,809	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,157	14,802	8,668	71,627	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.27%

D. How many bed-hold days during this year were paid by Public Aid?
411 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/01/85

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/85 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 22 and days of care provided 5,612

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	254,019	25,036	6,530	285,585		285,585	0	285,585			1
2	Food Purchase		248,028		248,028		248,028	(840)	247,188			2
3	Housekeeping	189,363	35,096	0	224,459		224,459	0	224,459			3
4	Laundry	149,193	31,593	3,770	184,556		184,556	0	184,556			4
5	Heat and Other Utilities			195,606	195,606		195,606	0	195,606			5
6	Maintenance	87,775	32,204	31,156	151,135		151,135	4,929	156,064			6
7	Other (specify):*			20,824	20,824		20,824	0	20,824			7
8	TOTAL General Services	680,350	371,957	257,886	1,310,193	0	1,310,193	4,089	1,314,282			8
	B. Health Care and Programs											
9	Medical Director	0		29,800	29,800		29,800	0	29,800			9
10	Nursing and Medical Records	2,496,448	163,066	13,726	2,673,240		2,673,240	0	2,673,240			10
10a	Therapy	113,751		2,283	116,034		116,034	0	116,034			10a
11	Activities	148,877	1,714	1,612	152,203		152,203	0	152,203			11
12	Social Services	27,468		806	28,274		28,274	0	28,274			12
13	Nurse Aide Training			3,019	3,019		3,019	0	3,019			13
14	Program Transportation			2,660	2,660		2,660	0	2,660			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	2,786,544	164,780	53,906	3,005,230	0	3,005,230	0	3,005,230			16
	C. General Administration											
17	Administrative	218,981		951,500	1,170,481		1,170,481	0	1,170,481			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			61,954	61,954		61,954	0	61,954			19
20	Dues, Fees, Subscriptions & Promotions			39,966	39,966		39,966	(8,940)	31,026			20
21	Clerical & General Office Expenses	175,259	31,872	31,842	238,973		238,973	(6,323)	232,650			21
22	Employee Benefits & Payroll Taxes			681,221	681,221		681,221	0	681,221			22
23	Inservice Training & Education			12,728	12,728		12,728	0	12,728			23
24	Travel and Seminar			0	0		0	0	0			24
25	Other Admin. Staff Transportation			74,060	74,060		74,060	0	74,060			25
26	Insurance-Prop.Liab.Malpractice			136,625	136,625		136,625	0	136,625			26
27	Other (specify):*			24,198	24,198		24,198	(24,198)	0			27
28	TOTAL General Administration	394,240	31,872	2,014,094	2,440,206	0	2,440,206	(39,461)	2,400,745			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,861,134	568,609	2,325,886	6,755,629	0	6,755,629	(35,372)	6,720,257			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER #0030015 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			430,621	430,621		430,621	(37,993)	392,628			30
31	Amortization of Pre-Op. & Org.			21,180	21,180		21,180	0	21,180			31
32	Interest			691,888	691,888		691,888	0	691,888			32
33	Real Estate Taxes			77,656	77,656		77,656	0	77,656			33
34	Rent-Facility & Grounds				0		0	0	0			34
35	Rent-Equipment & Vehicles			77,336	77,336		77,336	0	77,336			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			1,298,681	1,298,681	0	1,298,681	(37,993)	1,260,688			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		193,980	196,190	390,170		390,170	0	390,170			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			117,713	117,713		117,713	0	117,713			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	193,980	313,903	507,883	0	507,883	0	507,883			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,861,134	762,589	3,938,470	8,562,193	0	8,562,193	(73,365)	8,488,828			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(37,993)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(840)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	(150)	20		17
18	Fines and Penalties	(6,323)	21		18
19	Entertainment	0	20		19
20	Contributions	(4,778)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,198)	27		24
25	Fund Raising, Advertising and Promotional	(4,012)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule SEE PAGE 5A	4,929			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (73,365)		$ 0	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	0		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 0		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (73,365)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
WESTMONT CONVALESCENT CENTER
ID# 0030015
Report Period Beginning: 01/01/2001
Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 4929	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	4,929		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(840)	0	0	0	0	0	0	0	0	0	0	(840)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	4,929	0	0	0	0	0	0	0	0	0	0	4,929	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	4,089	0	0	0	0	0	0	0	0	0	0	4,089	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(8,940)	0	0	0	0	0	0	0	0	0	0	(8,940)	20
21	Clerical & General Office Expenses	(6,323)	0	0	0	0	0	0	0	0	0	0	(6,323)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(24,198)	0	0	0	0	0	0	0	0	0	0	(24,198)	27
28	**TOTAL General Administration**	(39,461)	0	0	0	0	0	0	0	0	0	0	(39,461)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(35,372)	0	0	0	0	0	0	0	0	0	0	(35,372)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number WESTMONT CONVALESCENT CENTER **#** 0030015 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(37,993)	0	0	0	0	0	0	0	0	0	0	(37,993)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(37,993)	0	0	0	0	0	0	0	0	0	0	(37,993)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(73,365)	0	0	0	0	0	0	0	0	0	0	(73,365)	45

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		SEE ATTACHED SCHEDULE				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	FLORA WEISS	GEN. PARTNER	ADMINISTRAT.	0.223256	0	56	90	MGMT FEE	$ 475,750	17-3	1
2	DANIEL WEISS	ASST. ADM	ADMINISTRAT.	0		8	20	SALARY	46,306	17-1	2
3	SCHIRLEY HOLT	GEN. PARTNER	ADMINISTRAT.	0.1628	0	60	100	MGMT FEE	475,750	17-3	3
4	RICHARD HOLT	GEN. PARTNER	SECURITY	0	0	3	5	OUTS. LAB	4,800	6-3	4
5	NANCY GERACI	ADMINISTRAT.	ADMINISTRAT.	0.0093	0	40	100	SALARY	109,556	17-1	5
6	SHARON HAUGH	BOOKKEEPER	CLERICAL	0.0093	0	20	50	SALARY	42,553	21-1	6
7	JANE HOLT	CLERK	CLERICAL	0	0	12	0	SALARY	12,000	21-1	7
8	VASCO HOLD	CLERK	CLERICAL	0	0	14	0	SALARY	25,200	21-1	8
9	AVRUM WEINFELD	CONSULTANT	COMP. CONS.	0		12	0	SALARY	11,550	21-1	9
10											10
11											11
12											12
13								TOTAL	$ 1,203,465		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	KEY COMMERCIAL		X	MORTGAGE	$84,015.00	05/01/98	$ 10,000,000	$ 9,421,894	05/01/23	7.2800	$ 691,888	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$84,015.00		$ 10,000,000	$ 9,421,894			$ 691,888	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 10,000,000	$ 9,421,894			$ 691,888	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 73,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 75,156	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,356	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 76,300	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 77,656	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	68,221	8
	1997	70,426	9
	1998	72,625	10
	1999	72,603	11
	2000	75,156	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WESTMONT CONVALESCENT CENTER COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0030015

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-22-101-001	NURSING HOME	$ 71,605.78	$ 71,605.78
2.	09-22-101-002	NURSING HOME	$ 3,550.66	$ 3,550.66
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 75,156.44	$ 75,156.44

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,928 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1995	$ 349,103	1
2					2
3	TOTALS			$ 349,103	3

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	215		1995		$ 4,982,301	$ 127,746	39	$ 127,746	$	$ 867,766	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FLOORING			1986	41,641	2,207	19	2,192	(15)	32,283	9
10	ROOF &WATER LINE			1987	31,143	989	20	1,557	568	22,569	10
11	IMPROVEMENTS			1988	44,614	1,417	31.5	1,417		19,110	11
12	IMPROVEMENTS			1989	40,935	1,299	31.5	1,299		16,179	12
13	DRIVEWAY			1989	17,137	1,142	15	1,142		11,180	13
14	IMPROVEMENTS			1990	37,367	1,187	31.5	1,187		13,587	14
15	IMPROVEMENTS			1991	45,002	1,428	31.5	1,428		14,755	15
16	IMPROVEMENTS			1992	49,649	1,577	31.5	1,577		14,888	16
17	ROOF TOP A/C UNITS			1993	9,100	289	31.5	289		2,577	17
18	IMPROVEMENTS			1993	53,243	1,366	39	1,366		11,461	18
19	IMPROVEMENTS			1994	31,230	801	39	801		6,124	19
20	FLOOR COVERING			1995	795	20	15	53	33	371	20
21	HAND RAIL			1995	2,249	58	39	58		399	21
22	FLOOR & TILES			1995	5,471	140	39	140		928	22
23	WINDOW A/C UNITS			1995	14,146	363	39	363		2,343	23
24	ARJO TUB & ATTACHED PLUMBING			1995	12,056	309	39	309		2,022	24
25	ALARM			1995	1,337	34	39	34		220	25
26	LAUNDRY BUILDING			1995	35,000	897	39	897		5,644	26
27	ROOF			1995	5,520	142	39	142		893	27
28	WINDOWS			1995	9,478	243	39	243		1,509	28
29	DOOR EDGE & DOOR FRAME			1996	2,099	54	39	54		322	29
30	LAUNDRY BUILDING			1996	175,187	4,492	39	4,492		24,897	30
31	AIR COOLERS			1996	6,642	171	39	171		938	31
32	RACING CAGE			1996	3,987	102	39	102		565	32
33	HAND RAIL			1996	1,156	30	39	30		161	33
34	WINDOWS			1996	11,496	295	39	295		1,586	34
35	TACK ROOM			1996	2,139	55	39	55		291	35
36	NEW CONFERENSE ROOM-TILE			1997	2,938	76	39	76		326	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	INSTALL DIETARY DOOR	1997	$ 1,478	$ 38	39	$ 38	$	$ 163	37
38	NURSING STATION- 2ND FLOOR	1997	5,397	138	39	138		570	38
39	WINDOW-NURSING OFFICE	1997	1,382	35	39	35		144	39
40	REPLACEMENT A/C HEATING UNIT	1997	1,107	28	39	28		139	40
41	NURSING STATION-FLOOR TILES, HANDRAILS	1997	4,927	126	39	126		468	41
42	THE PARKING LOT	1998	42,711	2,847	15	2,847		8,778	42
43	KICHEN BACK-REPLACE TILES, SIX ROOMS- INSTALL TIL	1998	6,223	160	39	160		623	43
44	INSTALL 6" SEWER, 10 EMERGENCY PULL CORD	1998	12,715	326	39	326		1,019	44
45	GENERATOR BACK-UP HOOK-UP TO ELEVATOR	1999	10,473	269	39	269		796	45
46	REPLACEMENT OF WATER HEATER - 1-ST FLOOR	1999	3,452	89	39	89		241	46
47	ANSUL FIRE SUPPRESSI ON SYSTEM INSTALL	1999	1,495	38	39	38		103	47
48	SEALCOATING, REPAIRS & LINING	1999	2,877	74	39	74		194	48
49	REMODELING F WING SHOWER ROOM	1999	8,988	230	39	230		585	49
50	REPLACE DEFECTIVE SMOKE DETECTORS	1999	2,370	61	39	61		150	50
51	THE NEW PROXIMITY ELEVATOR DOOR EDGE	1999	2,760	71	39	71		157	51
52	WATER HEATER - DIETARY	1999	2,931	75	39	75		159	52
53	ROOF TOP - TWO EXHAUST FANS	1999	3,073	79	39	79		168	53
54	TILE - DINING ROOM	1999	1,212	31	39	31		66	54
55	ROOF - REPAIRS AND COATINGS	1999	7,200	185	39	185		393	55
56	REPLACE HEAT EXCHANGER IN YORK ROOF TOP UNIT	1999	2,738	70	39	70		143	56
57	WINDOW TREATMENT, DRAPERY	2000	3,265	833	20	163	(670)	326	57
58	WATER HEATER-DIETARY	2000	3,573	130	27.5	130		168	58
59	GENERAL CONSTRUCTION	2000	27,448	998	27.5	998		1,206	59
60	ROOF REPAIR	2000	4,200	153	27.5	153		185	60
61	REPLACE ELECTRIC PANEL INTERIOR	2000	2,910	106	27.5	106		110	61
62	NEW A/C UNIT ROOF TOP	2000	4,694	171	27.5	171		178	62
63	WALLCOVERING, FLOORING, LIGHTING	2000	80,523	22,184	20	4,026	(18,158)	8,052	63
64	SHOWER ROOM RENOVATIONS	2001	30,586	881	27.5	881		881	64
65	DURO-LAST ROOFING SYSTEMS	2001	107,341	1,464	27.5	1,464		1,464	65
66	WATER HEATER-LAUNDRY	2001	9,108	14	27.5	14		14	66
67	ROOF TOP-HEATING & COOLING UNITS	2001	12,464	19	27.5	19		19	67
68		2001	270,861	27,340	20	13,543	(13,797)	13,543	68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,357,540	$ 208,192		$ 176,153	$ (32,039)	$ 1,117,099	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,357,540	$ 208,192		$ 176,153	$ (32,039)	$ 1,117,099	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,357,540	$ 208,192		$ 176,153	$ (32,039)	$ 1,117,099	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,923,815	$ 176,007	$ 193,820	$ 17,813	4-15	$ 1,187,503	71
72	Current Year Purchases	156,482	46,422	22,655	(23,767)	8-10	22,655	72
73	Fully Depreciated Assets	168,987			0		168,987	73
74					0			74
75	TOTALS	$ 2,249,284	$ 222,429	$ 216,475	$ (5,954)		$ 1,379,145	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,955,927	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 430,621	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 392,628	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (37,993)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,496,244	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 41,367 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	HSKP, MAINT.	1998 DODGE VAN	$ 550.00	$ 2,450	17
18	HSKP, MAINT.	2001 CHEVROLET	775.00	5,348	18
19	ADMINISTRATIVE	2001 JAGUAR	915.00	13,014	19
20	ADMINISTRATIVE	2001 BMW	1,245.00	15,157	20
21	TOTAL		$ 3,485.00	$ 35,969	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[X]
COMMUNITY COLLEGE	[ ]
HOURS PER AIDE	71

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	[X]
IN OTHER FACILITY	[ ]
HOURS PER AIDE	20

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies		1,804		1,804
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests		1,215		1,215
9	TOTALS	$ 0	$ 3,019	$ 0	$ 3,019
10	SUM OF line 9, col. 1 and 2 (e)	$ 3,019			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	8
2. From other facilities (f)	1
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	9

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 69,499	$		$ 69,499	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			21,297			21,297	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			105,394			105,394	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				142,363		142,363	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	RENTAL, LAB, RADIOLOGY Other (specify): MEDICAL SUPPLIES	39-2 39-2					19,445 32,172		19,445 32,172	13
14	TOTAL			$		$ 196,190	$ 193,980		$ 390,170	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,116,253	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,384,689		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	226,260		6
7	Other Prepaid Expenses	12,772		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Real Estate Dep. & Insurance	67,530		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,807,504	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	349,103		13
14	Buildings, at Historical Cost	4,982,301		14
15	Leasehold Improvements, at Historical Cost	1,375,239		15
16	Equipment, at Historical Cost	2,249,284		16
17	Accumulated Depreciation (book methods)	(3,125,739)		17
18	Deferred Charges	254,413		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Amort of DEF MTG Costs	(77,660)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,006,941	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,814,445	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 238,886	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	129,689		30
31	Accrued Taxes Payable (excluding real estate taxes)	56,157		31
32	Accrued Real Estate Taxes(Sch.IX-B)	76,300		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 501,032	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	9,421,894		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 9,421,894	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,922,926	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,108,481)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,814,445	$ 0	48

***(See instructions.)**

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (809,032)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (809,032)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,151,801	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,451,250)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (299,449)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,108,481)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,487,701	1
2	Discounts and Allowances for all Levels	(180)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,487,521	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	119,736	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 119,736	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	11,454	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 11,454	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	81,028	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 81,028	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS	14,097	28
28a	VENDING COMMISSIONS	158	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 14,255	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,713,994	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,310,193	31
32	Health Care	3,005,230	32
33	General Administration	2,440,206	33
	B. Capital Expense		
34	Ownership	1,298,681	34
	C. Ancillary Expense		
35	Special Cost Centers	390,170	35
36	Provider Participation Fee	117,713	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,562,193	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,151,801	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,151,801	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,424	$ 72,594	$ 29.95	1
2	Assistant Director of Nursing	2,080	2,219	55,996	25.23	2
3	Registered Nurses	39,398	44,331	862,235	19.45	3
4	Licensed Practical Nurses	8,133	9,630	176,225	18.30	4
5	Nurse Aides & Orderlies	107,683	112,560	1,065,941	9.47	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,610	8,832	113,751	12.88	8
9	Activity Director	2,080	2,425	39,966	16.48	9
10	Activity Assistants	12,637	13,298	108,911	8.19	10
11	Social Service Workers	2,008	2,274	27,468	12.08	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,671	43,011	16.10	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,597	27,547	211,008	7.66	15
16	Dishwashers					16
17	Maintenance Workers	7,066	7,510	87,775	11.69	17
18	Housekeepers	30,733	31,928	189,363	5.93	18
19	Laundry	23,133	24,304	149,193	6.14	19
20	Administrator	2,080	2,125	109,556	51.56	20
21	Assistant Administrator	4,769	5,193	109,425	21.07	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,858	12,709	175,259	13.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	14,166	16,949	212,869	12.56	31
32	Other Health Care(specify)					32
33	Other(specify) Care Plan Superv	2,080	2,337	50,588	21.65	33
34	TOTAL (lines 1 - 33)	307,271	331,266	$ 3,861,134 *	$ 11.66	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	102	$ 5,081	1-3	35
36	Medical Director	Monthly	29,800	9-3	36
37	Medical Records Consultant	24	1,200	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	Monthly	2,220	10-3	39
40	Physical Therapy Consultant	42	2,283	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	32	1,612	11-3	44
45	Social Service Consultant	20	806	12-3	45
46	Other(specify)				46
47	UTILIZATION REVIEW FEES	Monthly	3,300	10-3	47
48					48
49	TOTAL (lines 35 - 48)	220	$ 46,302		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	358	7,006	10-3	52
53	TOTAL (lines 50 - 52)	358	$ 7,006		53

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
NANCY GERACI	ADMIN	0.93	$ 109,556
MARY LYNN MOUNT	ASST ADMIN	0	47,887
DANIEL WEISS	ASSIT ADM	0	46,306
BARBARA WULF	ASSIT ADM	0	15,232
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 218,981

B. Administrative - Other

Description		Amount
FLORA WEISS	MANAGEMENT FEE	$ 475,750
SHIRLEY HOLT	MANAGEMENT FEE	475,750
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		$ 951,500

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA	DATA PROCESSING	$ 6,505
HEALTH DATA SYSTEM	DATA PROCESSING	11,159
EARTHLINK,SOURCETECH	DATA PROCESSING	222
HC/ACCU-MED	DATA PROCESSING	1,750
KRUPNICK, BOKOR, KAGDA	ACCOUNTING FEE	11,100
RICHARD PEELO	MEDICARE CONSULT	4,500
PERESONNEL PLANNERS	U/C CONSULTANT	792
LARRY CHAMBERS	LEGAL FEE	2,602
ACHIEVE ACCREDITATION	INSPECTION	2,424
SACHNOFF & WEAVER	LEGAL FEE	19,555
LAWRENCE SCHWARTZ	LEGAL FEE	615
POLSINELLI SHALTON WELTE	LEGAL FEE	730
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 61,954

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 155,923
Unemployment Compensation Insurance	29,876
FICA Taxes	289,313
Employee Health Insurance	109,343
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	94,109
EMPLOYEE PHYSICAL EXAMS	2,657
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 681,221

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	24,917
Health Care Worker Background Check	30
(Indicate # of checks performed 3)	
MARKETING/ADV/PROMO	4,012
TRUST FEES/FRANCHISE TX/ETC	150
CONTRIBUTIONS	4,778
DUES & SUBSCRIPTIONS	5,262
LICENSES & PERMITS	617
CONTRIB/TRUST FEES//ETC	(4,928)
Less: Public Relations Expense	(0)
Non-allowable advertising	(4,012)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,026

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	7/98	$ 7,598	3 YR	$ 1,267	$ 2,532	$ 3,532	$ 1,267	$	$	$	$	$
2	PAINT/DECORATING	7/99	9,577	3 YR		1,596	3,192	3,192	1,597				
3	PAINT/DECORATING	7/00	7,646	3 YR			1,274	2,549	2,549	1,274			
4	PAINT/DECORATING	7/01	2,495	3 YR				416	832	832	415		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 27,316		$ 1,267	$ 4,128	$ 7,998	$ 7,424	$ 4,978	$ 2,106	$ 415	$	$

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $4557**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **45,466** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
WESTMONT TERRACE NURSING CENTER, #0025981. 9/1/85

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **117,713**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: WESTMONT CONVALESCENT CENTER #0030015 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,081	
	REPAIRS & MAINTENANCE		1,449	
			0	6,530
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		3,770	
			0	3,770
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		43,681	
	ELECTRICITY		84,402	
	WATER		67,523	
	CABLE TV - LOBBY		0	
			0	195,606
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		6,965	
	PAINTING & DECORATING		2,495	
	BUILDING REPAIRS		2,099	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		1,679	
	ELEVATOR MAINTENANCE & REPAIR		3,793	
	OUTSIDE LABOR		4,841	
	EXTERMINATING SERVICE		4,270	
	FIRE SERVICE		5,014	
			0	
			0	
			0	31,156
7	**OTHER**			
	SCAVENGER		20,824	
	SECURITY SERVICE		0	20,824
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	29,800	29,800

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	7,006	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,200	
	PHARMACY CONSULTANT	XVIII B 39-2	2,220	
	UTILIZATION REVIEW FEES	XVIII B __-2	3,300	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	13,726
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	2,283	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	2,283
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,612	
			0	1,612
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	806	
			0	806
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	3,019	3,019

Facility Name & ID Number WESTMONT CONVALESCENT CENTER #0030015 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		2,660	2,660
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	951,500	951,500
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	19,636	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	42,318	
			0	61,954
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	4,012	
	EMPLOYEE WANT ADS	XIX F	24,917	
	CONTRIBUTIONS	VI 20 XIX F	1,000	
	DUES & SUBSCRIPTIONS	XIX F	5,262	
	LICENSES & PERMITS	XIX F	817	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	150	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	3,778	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	30	39,966
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		389	
	EQUIPMENT REPAIR & MAINTENANCE		1,819	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	6,323	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		23,311	
	MESSENGER SERVICE		0	
			0	31,842

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	289,313	
	UNEMPLOYMENT COMPENSATION	XIX D	29,876	
	WORKERS COMPENSATION INSURANC	XIX D	155,923	
	HOSPITALIZATION INSURANCE	XIX D	109,343	
	EMPLOYEE BENEFITS - OTHER	XIX D	94,109	
	EMPLOYEE PHYSICAL EXAMS	XIX D	2,657	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	681,221
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		12,728	12,728
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G		
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		74,060	74,060
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		136,625	136,625
27	**OTHER**			
	BAD DEBTS	VI 24	24,198	
			0	24,198

GRAND TOTAL COLUMN 3 OTHER 2,325,886

WESTMONT CONVALESCENT CENTER
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	248,028	PATIENT MEALS	214881
LESS SALES TAX	(840)	ADD EMPLOYEE MEALS	0
NET FOOD	248868	TOTAL MEALS/YEAR	214881
TOTAL PATIENT CENSUS	71,627	NET FOOD	248868
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	214881
TOTAL PATIENT MEALS	214881	COST PER MEAL	1.16
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		